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Staff development a primary component in residential treatment

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STAFF DEVELOPMENT: A PRIMARY COMPONENT IN RESIDENTIAL TREATMENT

A Thesis

Presented to the

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In Partial Fulfillment

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ABSTRACT

The relationship between staff's positive mental health and their awareness of the needs of the male residents within an adolescent residential treatment center was studied. The subjects were 25 employees of a treatment center and all levels of staff were represented in the sample. The Personal Orientation Inventory (POI) and the Residential Staff Questionaire (RSQ), a new instrument developed for this study, were administered to the subjects. Analysis of the data showed a significant positive correlation between positive mental health and awareness of residents' needs but only for those staff whose job roles did not require supervision of residents. For those staff whose primary task was to supervise residents and who also held a college degree, there was a negative correlation between positive mental health and awareness of residents' needs. It was speculated from the results that those staff who are either static or only intellectually involved in their personal development show a correspondingly decreased capacity for awareness of residents' needs and rely upon control tactics in their interactions with residents. In addition, the results reconfirm the need for on-going inservice training for all levels of staff, college and professionally trained not excepted. However,

since the study had several limitations, the conclusions are stated with caution.

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INTRODUCTION

Sands (1964, pp. 17-19) describes his experience at the Preston School of Industry, a reform school in northern California in the 1930's, as "depressing and lonely." He was told to "obey the rules" and he would get along fine and "out that much sooner." Since the staff were not allowed to use corporal punishment, they relied upon inmate captains and inmate lieutenants "and you do what they say or you'll sure wish you had."

In contrast to Sands' experience, Bettelheim (1951, pp. 7-9) describes a rampage by a youngster who broke 32 windows in one day, a record for the Orthogenic School. Bettelheim states that "permitting" the rampage somehow led to a "turning point" in the youngster's life.

Present California legislation regulating residential care facilities (State, 1977) requires that a resident, prior to admission, participate in an assessment not only of his needs, but also of whether the facility is equipped to meet those needs.

These three examples are indicative of an evolution in residential treatment, and also reflect a change in social attitudes (Cressey, 1965; Meile, 1974). In today's society, the worth of the individual is gradually superseding the interests of the privileged class so that the

so-called maladjusted person, for example, not only has an opportunity for rehabilitation, but centers are built as an organizational base for his participation in society (Janowitz, 1966).

Custody-Treatment Continuum

Past and present trends in residential treatment can be represented by a custody-treatment continuum which describes variations in organizational goals (Kadushin, 1974; Street, Vinter and Perrow, 1966). Admittedly oversimplified, the continuum describes the tension within people-changing organizations to bureaucratize on the one hand and to become more aware of individual needs on the other. Parallel to the custody-treatment continuum is a more fundamental continuum of Western thought with a traditional belief in authority and the absolute at one end of the spectrum (Weber, 1946) and an awareness of processes and change at the other (Gendlin, 1973). The relationship between belief systems and organizational goals is often unrecognized, yet it determines the manner in which organizational subunits come together to form an organizational whole (Janowitz, 1966; Henry, 1957).

The residential treatment center is comprised of three organizational subunits: the residents who are the primary recipients of service, the staff who provide the

service, and the often nebulous entity of the institution itself (Blau and Schoenhers, 1971; Blau and Scott, 1962; Caudill, 1958; Jaffie, 1975; Parsons, 1960).

In a custodial setting, these subunits form a hierarchical structure in harmony with the changeless order of the universe (Cox, 1966). Within this kind of setting, the only changing element is the resident who is perceived as out of control, deviant, maladjusted to societal norms, and lacking insight into his behavior (Blau and Scott, 1962; Hurvitz, 1973; Polsky, 1962; Street et al., 1966). More accurately, the resident is not required to change but rather to conform. Residents who do not conform are thought to be unamenable to treatment or unable to adjust or mold themselves to the prescribed way of life (Rogers, 1961). Since the organization and staff are identified with authority, there is no demand upon them for movement or change. Finally, organizational roles are impersonal which leads to an efficient organization (Schallert, 1967; Vail, 1966; Weber, 1946).

There are several consequences for the resident in this type of setting. First, the resident is reduced to the objective status of a case (Weber, 1946). In turn, the case file contains numerous labels which identify a problem the resident has and only from a distorted view identify who the resident is. For example, court reports

refer to the youngster as the minor, and psychiatric reports refer to him or her as the patient. Needless to say, the resident has little control over these labels or the diagnostic process.

The custody-oriented institution or facility tends to focus on the resident's dysfunction and consequently distorts the functioning person (Redl, 1966; Rieger and Devries, 1974). A younster's entire behavior pattern becomes identified as predelinquent, delinquent, or emotionally disturbed. The resident can no longer behave normally. For example, if a youngster is angry, he or she cannot be just angry. Rather one is displaying an aggressive reaction to adolescence, an inability to accept responsibility for one's behavior, or at best one is attempting to manipulate the staff for attention.

Since the main goal of this type of institution is to control, the resident is never allowed to display his problem behavior. Acting out is a serious threat to institutional control. As a result of not experiencing freedom and the natural consequences of his choices, the resident may never develop a sense of responsibility for his choices. Consequently, he blames the people who react to his behavior with anger and rejection for his ill fate (Easson, 1969). The institution further assumes responsibility for a resident's choices by setting up elaborate

rewards and punishments which are considered by some to reflect the bribes and threats of a primitive society (Dreikurs, 1957). What were once individual rights become only privileges within the context of the institution's rules and regulations (Polsky, 1962). The extreme of this type of setting has been described as the total institution (Goffman, 1961).

The irony of this kind of organizational structure is that the facility can maintain control only when the residents allow themselves to be controlled (Haley, 1963). Consequently, the facility relies upon and reinforces the subculture which has its own elaborate, often pathological structures for controlling both the peer group and the institution (Hewitt, 1976; Kadushin, 1974; Ohlin and Lawerence, 1959; Polsky, 1962; Rubenfield and Stafford, 1963). The residents find themselves caught in a power struggle between themselves and the institution as well as between themselves and their peer group. Disruption of the balance of power can result in removal from the facility. This, in turn, acts as a negative reinforcement for the resident who becomes more firmly convinced that either the world is truly unjust or that he or she is indeed a social misfit in need of institutionalization.

In a non-traditional or treatment-oriented setting, the three organizational subunits come together to form what Jones (1953, 1968) calls a therapeutic community.

The organizational structure reflects a view of reality where there are no closed systems or absolutes. The organization does not presume to know what is best (Bettelheim, 1951; Slack and Slack, 1976) and consequently, does not rush in to correct things (Rogers, 1961, 1977). The organization creates a climate where change and growth take place on the part of the organization and staff as well as the residents. Rather than being imposed by force, order is modeled by the adult staff (Bettelheim, 1951, 1966). External force is replaced by internal stimulation (Dreikurs, 1957), and in this way, the organization becomes accountable for the residents' movement and change. Role relationships, in contrast to roles alone, are emphasized. Interpersonal relationships become the basis for a therapeutic milieu, and the actual persons in those roles become important (Bettelheim, 1966; Bettelheim and Sylvester, 1948; Easson, 1969). The organization's efficiency is assessed in terms of the institution's ability to meet the needs of all the people, both staff and residents, who are a part of its operations (Greenblatt, Sharaf, and Stone, 1971; Rolde, Fersch, Kelly, Frank, and Guberman, 1973; Stanton and Schwartz, 1954).

The consequences for the resident in the treatment setting are opposite to those of the custodial setting. First, the resident is accepted as a subject or person who has individual needs. The treatment center focuses on the

whole person to better understand any dysfunction (Redl, 1966; Rieger and Devries, 1974). Specifically, the residential treatment center is prepared to meet the needs of normal adolescents (Grinker, 1962; Offer, Sabshin, and Marcus, 1965). The resident can thus experience and express normal emotions without being guilty of some pathology. Labels of normal and abnormal are not as important as actual behavior which is accepted as a significant indicator of a resident's present status. It is also recognized that the institution forms a context of which the so-called disturbed behavior is a part (Jones, 1953). All behavior is seen as functional in some way within the conditions or the oeprations of the institution. Stanton and Schwartz (1954) cite the example of the patient whose apparent thirst was diagnosed as part of her illness when, in fact, the particular ward had no drinking fountains. Once drinking fountains were installed, the woman was no longer thirsty. Thus the treatment-oriented program allows leeway for the negative impact of the institution itself (Devereux, 1949). Accordingly, acting-out behavior is not always an indicator of a resident's problem, but is often simple resistance to institutionalization.

Within the treatment setting, residents are not rejected or punished for acting-out behavior. Rather, the youngster is allowed to come face to face with his or her

behavior and, initially, without the usual consequences. Acting out is not perceived as a threat to institutional control. The facility plans for and prepares strategically to work with the problem behavior. In this way, the facility gains control not of the residents but of the maladaptive behaviors (Bettelheim, 1951; Haley, 1963; Redl and Wineman, 1957; Rieger and Devries, 1974). Institutional controls are human based controls and intervention into the resident's world is made at a rate that the resident can tolerate (Easson, 1969). Gratification of needs, love, and affection are completely divorced from any deserving contingencies. Redl and Wineman (1957) make this point clear by citing the obvious error in withdrawing cough syrup from the person who keeps coughing.

Treatment concepts can influence organizational goals to the extent that one can begin to speak of a pluralistic institution in contrast to a total institution (Janowitz, 1966). The organization no longer needs to rely upon the deilinquent subculture for control but can create a therapeutic culture which reflects the attitudes, beliefs, and interpersonal processes of residents and staff alike (Henry, 1957; Jones, 1968; Slack and Slack, 1976).

Related Research

There is a striking contrast between the custodial and treatment orientation and the validity of the

continuum has been both questioned and supported. Moos (1975) developed a nine-point scale to measure both staff's and residents' perception of the social climate of the institutional setting. He concluded from his research that the phrase treatment-oriented is inadequate to describe any major component of correctional or psychiatric programs. Surprisingly, he found that a relatively high number of psychiatric programs have no treatment component at all. Therefore, Moos suggested the need for differential programing and implies that some individuals actually need a non-treatment approach. He supported these conclusions with findings that individual (Bergin, 1971) and group therapy (Lieberman, Yalom, and Miles, 1973) can have detrimental effects.

Although Moos presents empirical evidence to show that many people-changing organizations fall somewhere in the middle of the custody-treatment continuum, the bulk of the research, including Moos, points to the positive relationship between treatment orientation and improved staff, resident, and general organizational functioning. The fact that some people apparently get worse in a particular treatment setting does not warrant the conclusion that treatment in general is ineffective nor that treatment should be withdrawn or withheld in particular instances.

Street et al. (1966) support the treatment-custody continuum. Their research shows that institutions emphasizing obedience and conformity have negative effects on residents and cannot produce individual changes which increase the capacity to function in an open society. Kadushin (1974) also cites relevant research (Allerhand, 1966) that indicates that when institutional goals focus on adjustment and adaptation to institutional living, the residents are not prepared to live in the society at large.

In evaluating the effectiveness of treatment-oriented programs, Street et al. (1966) delineate two separate problems: behavior change and after care. They found that the closer the facility moved toward a treatment-orientation, the greater was the residents' development of personal and social controls. The maintenance of these skills without social reinforcement following release is the problem. Realistically, this problem is related to the financial limitations of most treatment centers in setting up after-care services.

Accounts by Bettelheim (1951) and Redl and Wineman (1957) support the treatment orientation. Although these authors do not provide statistical data, their daily recording of residents' behavior cannot be discounted and has research validity (Campbell and Stanley, 1966; Barlow and Hersen, 1973). Contrary to Moos' (1975) suggestion, these practitioners worked with a wide variety

of behavior problems and yet maintained a consistent treatment approach. Over and above a decrease in major symptomatology, the following behavioral changes were documented: an increased ability to use language as a means of communication, an increase of positive perceptions of people and places, a decrease of suspiciousness toward adults, an increased capacity for receiving affection, and an increased ability to utilize rules and routine constructively.

Polsky (1962) studied the life in a residential cottage from a sociological perspective. Polsky found the organizational structure of the institution actually subverting any treatment goals because of the organization's apparent need to control the delinquent subculture. Caudill, Redlich, Gilmore, and Brody (1952) noted a similar phenomenon in a psychiatric ward. Polsky affirms the need for organizational change which would enable the organization to penetrate and integrate the subculture into the organization rather than attempting to control and consequently having to accommodate to it. Using Mowrer's (1950, chap. 18) premise that human behavior is simultaneously effective on and affected by the social environment, Polsky notes that if the staff attempt to integrate the subculture by power and control, they will only reinforce the subculture's own primitive values of power and control.

Assessing people-changing organizations and accounting for what makes them function is a difficult task because the people involved in the operations of the organization are complex individuals. This unusually complex factor often defies common-sense analysis. For example, Slack and Slack (1976) tell of the sudden-hope phenomenon which explains why most prison riots occur after prison conditions begin to improve, not before. Stanton and Schwartz (1954) refer to the unrecognized forces which influence both staff and residents' behavior. These forces are often too numerous to filter out, let alone understand their interactive effects. The simplest factor to consider is the staff to resident ratio and how this one variable of organizational structure can alter an organization's functioning and its goals (Easson, 1969; Hylton, 1964; Kadushin, 1974).

The emphasis on treatment in contrast to control is not a contemporary concept. Research related to mental health organizations dates back at least to Sullivan (1931), and today the word treatment is almost a cliché (Kadushin, 1974). Jonsonn (1972) indicates that the increased emphasis on treatment is related to the changing clientele, and that the youngsters coming to the residential treatment center today are bringing different problems than youngsters in previous years. Perhaps

contemporary technology and urbanization have created new problems for young people. However, in the eighth century B.C., Hesiod was pointing out the recklessness of youth, their lack of restraint, and their disrespect for authority (GAP, 1968).

Staff Development

One of the crucial problems in creating a treatment setting in contrast to a custodial setting is staff development (Davids, Laffey, and Cordin, 1969; Portnoy, Biller, and Davids, 1972). Cressey (1965) disagrees in that he emphasizes the need to examine organizational conditions which produce staff conduct contrary to treatment goals. This point is well taken and, as indicated in the beginning of this discussion, belief systems and organizational goals do directly influence organizational functioning. However, given an organization whose goals are to provide treatment, the crucial element in carrying out these goals is the staff. As Bettelheim (1966) indicates, the ability or inability to carry out treatment goals is not a problem specific to lower echelon staff, but pervades even those who are professionally trained and reasonably assumed to have the ability to put treatment philosophies into practice. The key, as Bettelheim points out, is that the staff must be involved in an on-going personal growth process. Each staff person

with whom the resident comes into contact is an important person. Recognizing this can often be painful for the staff because the resident is always questioning: can the staff take care of me, can they help me with my problem, or are they incapable because they cannot solve similar problems within themselves?

Easson (1969) further points out that the residential staff must extend to the resident a human relationship which provides security and stability. In order to do this, the staff must be able to face and deal with their own feelings and emotions, however strong or primitive, in a constructive manner. Staff must be able to model the range of human emotions and the appropriate expression of them. The residents need the experience of living with adults who can accept their own limitations.

Marcuse (1967) also emphasizes that the emotional strength and integrity of the staff is a critical treatment component. As long as the staff are secure enough to face their own inner life, they can use this inner resource as an on-going diagnostic tool in their relationships with the residents (Hirschberg and Mandelbaum, 1957; Rosen, 1963; Caplan, 1966; Slack and Slack, 1976). For example, if a staff person realizes that anger causes withdrawal, then one can use this cue as a way to monitor oneself when he or she begins withdrawing from particular residents.

Many residents are particularly adept at recognizing staff idiosyncracies and use them to their advantage. For instance, if residents know that anger causes staff to withdraw, they may induce anger to avoid dealing with staff and having to confront their fear of relationships.

Jones (1968) affirms the necessity of training staff to become involved in a personal process of social learning in everyday life situations in order to guide residents through a similar process. Jones answers the criticism of spending more time and energy with staff than residents, as though the staff should come already prepared, by stating that training and treatment are inseparable. In order for the treatment setting to be effective, Jones argues that the learning and growth process must pervade all levels of administration, treatment personnel as well as the patients and their relatives.

From a somewhat different perspective, Shermon, Paynter, and Szurek (1949) found that problems occurring among staff have a direct consequence on the clinical conditions of the residents. There can be no understanding of the dynamics of an individual or group of residents without first looking at the dynamics of both individual staff members and the staff as a group.

Rieger and Devries (1974, p. 153) explain how so-called disturbed children have a way of frightening not only people in general but professionals as well. These children

manage to provoke the entire gamut of feelings in other people "ranging from a passionate desire to help, to feelings of pity, helplessness, despair, disgust, anger, and counter aggression" depending upon one's personality, degree of maturity, frustration level, and tolerance. Continued contact with normal living is the growth-producing factor in an effective treatment program and the prime prerequisite if a resident is to grow up to be a responsible adult.

The hypothesis of this study was that a direct relationship exists between a staff person's positive mental health and the recognition and acceptance of the residents' needs. In contrast to the traditional concept of mental health as the absence of psychopathology, neurosis, or dysfunction, positive mental health is defined as the ability or capacity to live according to one's potentials and limitations. The hypothesis further stated that those staff persons who were static or lacking with respect to positive mental health would rely upon personal and institutional control tactics as the basis for their interactions with residents.

Hypothesis

The following hypothesis was operationalized and tested. For a given group of residential staff members, there will be a significant positive correlation between the scores on an inventory which measures positive mental

health and the scores on a questionaire which measures both awareness of residents' needs and reliance upon control tactics.

METHOD

Subjects

The subjects were 30 employees of a residential treatment center in southern California. The facility serves a maximum of 40 adolescent males referred by both probation and welfare departments of various California counties. Of the 30 subjects, one was unable to participate because of deficient reading and writing skills, two declined to participate, and three partially participated by completing either the inventory or the questionaire but not both. The 25 subjects who participated fully were divided into 12 paired subgroups: (a) child-care and non-child-care staff, (b) operational and primary service staff, (c) school and non-school staff, (d) social work and non-social work staff, (e) college and non-college staff, and (f) male and female staff.

Child-care staff. These eight staff members are responsible for the direct supervision of the residents' daily routine and are often referred to as line staff. The mean age is 23.5.

Non-child-care staff. This subgroup is made up of all other staff, and the mean age is 32.6.

Operational staff. These nine staff members are responsible for the operations of the physical plant and

include clerical, cooking, housekeeping, and maintenance staff. The mean age is 35.7.

Primary service staff. This subgroup provides direct services to the residents, includes social work staff, child-care staff, and school staff, and has a total of 16 members. The mean age is 26.3.

School staff. These five staff members are teachers or aides who work in the on-grounds school program which is designed for the educationally handicapped. The mean age of this group is 27.2.

Non-school staff. This subgroup includes all other staff. The mean age is 30.3.

Social work staff. These three staff members are social workers, hold M.A. degrees, supervise child-care staff, and provide individual and group therapy for residents. The mean age is 32.3.

Non-social work staff. This subgroup includes all other staff. The mean age is 29.3.

College staff. These nine staff members hold at least a B.A. degree. The mean age is 27.6.

Non-college staff. These are all other staff and include those who may be attending college but have not graduated. The mean age is 30.8.

Male staff. The mean age of this subgroup of 15 staff members is 26.6.

Female staff. The mean age of this subgroup of nine staff members is 34.4.

The mean age for the total group of 25 staff members is 29.5 with ages ranging from 20 to 57. The total group as well as the various subgroups are representative of a variety of ethnic backgrounds. Table 1 illustrates the manner in which the subgroups overlap and also summarizes demographic information.

Materials

Personal Orientation Inventory. The Personal Orientation Inventory (POI) is an objective measure of positive mental health or psychological growth. The conceptual framework upon which the inventory is based is self-actualization theory (Maslow, 1954, 1962; Rogers, 1951, 1961; Shostrom, Knapp and Knapp, 1975), Riesman's et al. (1950) system of inner and other-directedness, and May's et al. (1958) and Perls' (1947, 1951) concepts of time orientation.

The POI consists of 150 paired statements, non-threatening in nature, which reflect commonly-held value orientations and contrasts those value orientations associated with positive mental health with those that are not.

a. I often make my decisions spontaneously.

b. I seldom make my decisions spontaneously.

Table 1

List of Twenty-five Subjects with Demographic Information and Subgroup Division

			Subject		Sex	Age	Ethnic Background
Non-Child-care Staff	Primary Service Staff	Social work Staff	1	*	F	41	B
			2	*	M	27	B
			3	*	M	29	C
		Child-care Staff	4		M	23	S
			5		M	26	S
			6		M	25	C
			7	*	F	22	C
			8	*	F	24	C
			9		M	22	B
			10	*	M	23	S
			11	*	M	23	S
		School Staff	12		M	24	C
			13		M	26	C
			14		M	26	C
			15	*	F	30	C
			16	*	M	30	C
	Operational Staff		17		F	45	C
			18		F	21	C
			19		M	32	S
			20		M	26	C
			21		F	20	C
			22		F	57	C
			23		F	54	C
			24		M	37	S
			25		F	30	S

Note. B = Black
C = Caucasian
S = Spanish surname

*College staff.

The items are drawn from a compilation of clinical observations from several therapists over a five-year period. Positive mental health is described by Knapp (1971) as utilizing one's talents and capabilities more fully, living in the present rather than in the past or future, functioning relatively autonomously, and tending to have a more benevolent outlook on life and on human nature than the average person.

POI scores are divided into 12 subscales. Three of the scales, time competent (Tc), nature of man, constructive (Nc), and synergy (Sy) were not used for the present research. The remaining nine scales are described below.

1. Inner-directed (I). The I scale measures the degree to which one is self-supporting and free from social pressures and expectations.

2. Self-actualizing value (SAV). This scale measures the extent to which one holds the values of the self-actualizing person who is described as being confident in his potential and comfortable with his limitations.

3. Existentiality (Ex). The Ex scale measures one's flexibility in the application of values.

4. Feeling reactivity (Fr). This scale measures sensitivity to one's needs and feelings.

5. Spontaneity (S). This scale measures one's ability to express feelings behaviorally.

6. Self-regard (Sr). The Sr scale measures the ability to value oneself because of one's strengths as a person.

7. Self-acceptance (Sa). Self-acceptance measures the ability to accept oneself in spite of weakness and the extent that one is free from the expectation to be perfect.

8. Acceptance of aggression (A). The A scale indicates the degree that one can accept angry feelings as a natural part of oneself and utilize energy from angry feelings in a constructive manner.

9. Capacity for intimate contact (C). This scale measures one's capacity for interpersonal relationships.

In view of the research cited below, the I, SAV, Ex, S, and A scales were considered to be the principle predictor scales.

Validity. The construct validity of this instrument seems well substantiated by Shostrom's (1964) initial studies in which he successfully discriminated between clinically judged self-actualizing, normal, and non-self-actualizing adult groups.

The concurrent validity of the instrument has been evaluated by Shostrom and Knapp (1966), and in this study, they successfully discriminated between beginning and

advanced outpatient therapy groups. Fox (1965) and Fox, Knapp, and Michael (1968) further support the criterion validity with data which indicate that the inventory can be used to discriminate between hospitalized psychiatric patients and the original self-actualizing, normal, and non-self-actualizing groups. There are numerous other studies reported by both Shostrom (1974) and Knapp (1971) which have used this instrument successfully in evaluating a variety of criterion groups and social issues, for example, alcoholics (Zaccaria and Weir, 1967; Weir and Gade, 1969), Peace Corps volunteers (Fernald, 1974), psychopathic felons (Fisher, 1968), academic achievement in high school and college students (Lieb and Snyder, 1967; Pearson, 1966; Le May and Damm, 1968; Weber, 1970), and the effectiveness of various group therapy modes (Aubry, 1970; Byrd, 1967; Culbert, Clark, and Bobele, 1968; Flanders, 1969; Guinan and Foulds, 1970; Harvey, Di Luzio and Hunter, 1975; Rueveni, Swift, and Bell, 1969; Trueblood and McHolland, 1971; Young and Jacobson, 1971). In all of these studies, significant relationships were obtained between POI scores and the specific criteria under investigation.

Of particular relevance to this present research are those studies which have utilized the POI to support the hypothesis that positive mental health or psychological

growth is a facilitative factor in such interpersonal situations as counseling, teaching, parenting, and supervising as well as a factor in establishing positive organizational climate. Foulds (1969) studied the relationship between counselors' positive mental health, as measured by the POI, and their ability to relate to clients, as rated by judges. The findings were significant for 6 of 12 POI scales on counselors' ability to understand the client, and for 10 of 12 scales on counselors' ability to facilitate a therapeutic interaction. McClain (1970) has reported similar findings from his study of guidance counselors. Correlations between a composite positive mental health rating and POI scales ranged from .23 to .69 with 9 of the 12 correlations being significant. The highest correlations were with the I scale (r = .69), Sa scale (r = .56) and S scale (r = .53). Graff and Bradshaw (1970) and Graff, Bradshaw, Danish, Austin and Altekruse (1970) have presented evidence that scores on the POI are highly related to dormitory assistant effectiveness as measured by ratings of students and personnel deans. Correlations showed the primary predictor variables to be the I, SAV, S, and A scales. Dandes (1966) measured the psychological health of teachers as measured by the POI and teacher effectiveness as measured by the Minnesota Teacher Attitude Inventory. Correlations between the two instruments were positive and ranged from .15 to .40. Also

pertinent to the hypothesis are Swift's (1966) findings that high scores on the POI correlate with a lower need in parents to control a child's behavior. Ford (1966) and Margulies (1969) utilized the inventory to measure the relationship between positive mental health and organizational climate, and concluded that such key organizational elements as values, attitudes, and behavioral norms are related to the degree of psychological growth of the members of the organization.

There have been correlational studies between the POI and the MMPI (Shostrom and Knapp, 1966), the Eysenck Personality Inventory (Knapp, 1965), the Study of Values Scales (Ilardi and May, 1968), the Sixteen Personality Factor Questionaire and the Guilford-Zimmerman Temperament Survey (Meredith, 1967), Edwards Personal Preference Survey (Le May and Damm, 1969), and the Gordon Personal Inventory (Braun and Asta, 1968). All of the above studies found significant correlations in the expected directions. Negative correlations were obtained between POI scores and measures of authoritarianism and dogmatism (Dandes, 1966; Flanders, 1969; Mace, 1970; Pines, 1970; Provost, 1970).

Reliability. Klavetter and Mogar (1967) administered the inventory twice within a one-week interval to a group of 48 college students. All test-retest correlations ranged from .52 to .82. Ilardi and May (1968) examined the

stability of the inventory among a group of 46 student nurses over a one-year period. They reported coefficients ranging from .32 to .74. These findings appear to be well within the ranges of somewhat comparable MMPI and Edwards Personal Preference Survey test-retest reliability studies (Shostrom, 1974). One obvious problem in establishing test-retest reliability over any length of time is the nature and purpose of this instrument, namely, to measure growth. There are several studies which have tested the inventory's resistance to faking and attempts to make a good impression (Shostrom, 1974; Knapp, 1971), and lie score profiles are available in the test manual for identification of this phenomenon.

The internal consistency of the POI may be weak because of the item overlap among the various scales. The I scale correlates most significantly with the other scales since this one scale does account for the major part of the variance in the test (Shostrom, 1974). Therefore, Klavetter and Mogar (1967, p. 422) concluded that the POI is a "highly stable and sufficiently valid measure of health-growth dimensions of personal functioning"; however, the internal properties of the test such as stability, independence and utility of the 10 subscales are unclear. Although there may be some weaknesses in the instrument, it nevertheless does seem to provide an overall

valid and reliable predictor of positive mental health as indicated by the studies cited above.

Scoring. The subject is asked to mark the one of two paired statements which is most applicable to himself. Raw scores for the 12 subscales are obtained by adding up the number of penciled responses showing through the respective scale templates. Profiles for each subject were plotted and compared with normative data.

Norms. Normative data for normal adults, college students, and other occupational and clinical groups are available in the POI manual (Shostrom, 1974). In the present study, norms for the normal and self-actualizing adult groups were used.

Residential Staff Questionaire. The Residential Staff Questionaire (RSQ) is an instrument developed by the present author (see Appendix A). The conceptual framework for the questionaire is based upon the treatment-custody continuum discussed earlier. The questionaire presents ten problematic situations common to residential treatment centers. Each situation is accompanied by three possible solutions which represent three factors that may influence a staff person's interaction with residents: awareness of residents' needs, reliance upon personal control tactics, and reliance upon institutional control tactics. Awareness

of residents' needs is defined as the staff person's ability to recognize and accept problematic behavior as an integral part of the residents' present experience. Personal control tactics are defined as those methods which reinforce the staff person's authority and control over the resident, and institutional control tactics are defined as those rules and regulations designed to bring about conformity among the residents. Corresponding to these three factors are four RSQ scales: personal control scale (Pc), residents' needs scale (Rn), institutional control scale (Ic), and control scale (Cs), which is the combined Pc and Ic score.

Validity. The questionaire is straightforward in its presentation of the problematic situation and the three solutions. Each solution is highlighted by a key sentence. For example, "This youngster must learn to respect adult authority" or "Acting out can be an important step in learning other forms of emotional expression."

The construct validity of the questionaire was evaluated in a pilot study in which 10 employees from a residential treatment center, nine members of a group psychotherapy training group, and 10 people from a rural community of southern California, participated. Employees from the residential treatment center responded in the control direction more often than either of the other two

groups, and less often in the direction of residents' needs. Statistical analysis of the means was found to be significant. Table 2 presents the RSQ mean scores for the three groups.

Reliability. The reliability of the RSQ was evaluated in a pilot study in which 19 subjects from a rural neighborhood in southern California responded to the questionaire twice within an average test-retest interval of two weeks. Test-retest correlations for the Rn and Cs scores were high, .85 and .86 respectively. Correlations for the Pc and Ic scores were predictably somewhat lower, .68 and .57 respectively.

Scoring. The subject is asked to choose the solution which best explains his personal approach to working with troubled youth or which best describes the way he would take care of a given situation. Each response is scored as one, and the four scale scores are accumulated as illustrated in Table 2 below.

Norms. Although data are limited, analysis seems to suggest that scores are normally distributed and variance is related to one's association with either an institutional setting (refer to Table 2) or an occupation where control is an issue. For example, a law-enforcement officer and his wife who participated in one of the pilot studies obtained very high control scores. For those subjects

Table 2

Statistical Differences between RSQ Means

for Pilot Study Groups

	Pc	Rn	Ic	Cs
Residential Employees n = 10				
Mean	2.5	3.9	3.6	6.1
SD	1.9	2.4	3.0	2.6
Training Group n = 9				
Mean	1.4	7.6	.8	2.33
SD	1.5	2.3	1.5	2.5
t		3.42***	2.52**	3.22***
Rural community n = 10				
Mean	2.2	6.1	1.6	3.8
SD	1.6	2.8	1.5	2.9
t		1.77*	1.78*	1.76*

*p<.05, 1 tailed test, 18 df
**p<.02, 1 tailed test, 17 df
***p<.005, 1 tailed test, 17 df

associated with an institutional setting, score variation seems to be related to job role. For example, child-care workers in a residential setting obtained high control scores while social workers obtained high Rn scores. In a hospital setting, student nurses obtained high Rn scores.

Procedure. Staff members were approached individually by a familiar co-worker who was a social worker. He asked each staff member to participate in a research project which was gathering information about the care and treatment of young people in placement. The staff person was then presented with a packet containing both the POI and the RSQ. Neither instrument requires assistance beyond the written instructions. Any questions were answered by referring to these instructions. Staff were assured that all information was confidential and solely for research purposes. It was also announced that at a later date, the overall results of the research would be made available, and any personal inquiries regarding individual responses would be welcomed.

RESULTS

This study investigated the relationship between positive mental health as measured by the POI, and awareness of residents' needs as measured by the RSQ. The Pearson *r* analysis was performed to examine the hypothesized relationship, and the .05 level of significance was established as the level for acceptance or rejection of the hypothesis. The results show a significant positive correlation between the principle POI scales and the RSQ *Rn* for specific subgroups, but not for the total group.

Table 3 presents the correlations obtained for total group scores. Although there are no significant correlations between any of the predicted POI scales and the

Table 3

Correlations Between POI Scales and RSQ *Rn* Scale for Total Group Scores[a]

POI SCALES								
I	*SAV*	*Ex*	*Fr*	*S*	*Sr*	*Sa*	*A*	*C*
.249	.153	.312	.172	.168	.123	.217	-.036	.667*

[a] $n = 25$
*$p < .01$

RSQ Rn scale, there is a significant positive correlation between the RSQ Rn scale and the POI C scale which measures one's capacity for close interpersonal relationships.

Table 4 shows the correlations for scores of the child-care staff and non child-care staff subgroups. For the non child-care staff subgroup, there are significant positive correlations between 4 of the 5 principle POI scales and the RSQ Rn scale.

Table 4

Correlations Between POI Scales and RSQ Rn Scale for Child-care and non Child-care Staff Subgroups

		POI SCALES								
Group	n	I	SAV	Ex	Fr	S	Sr	Sa	A	C
Child-care Staff	8	-.334	-.034	-.182	-.270	-.579	-.329	-.608	-.260	.069
Non Child-care Staff	17	.630***	.447	.503*	.472	.528**	.300	.374	.518*	.362

Note. Negative correlations resulted generally from high POI scores and low RSQ Rn scores.

*p<.05
**p<.02
***p<.01

Correlations for the operational and primary service staff subgroups are given in Table 5. For the operational staff subgroup, there are significant correlations between 5 POI scales and the RSQ Rn scale. There are no significant correlations within the primary service staff subgroup.

Table 5

Correlations Between POI Scales and RSQ Rn Scale for Operational and Primary Service Staff Subgroups

		POI SCALES								
Group	n	I	SAV	Ex	Fr	S	Sr	Sa	A	C
Operational Staff	9	.858***	.324	.775**	.616	.863***	.081	.849***	.682*	.583
Primary Service Staff	16	.088	.127	.169	.046	÷028	÷231	.037	÷259	.227

*p<.05
**p<.02
***p<.01

Table 6 provides the correlations obtained for the college, non college, male, and female subgroups. The non college staff subgroup obtained significant positive correlations between 3 POI scales and the RSQ Rn scale.

Table 6

Correlations Between POI Scales and RSQ Rn Scale for College, non College, Male, and Female Subgroups

Group	n	I	SAV	Ex	Fr	S	Sr	Sa	A	C
College	9	-.227	-.397	-.163	-.214	-.222	-.859***	.138	-.189	.066
Non College	16	.625***	.347	.564*	.467	.515*	.173	.270	-.026	.469
Male	15	.130	.138	.235	.075	.047	.108	.018	-.294	.337
Female	10	.512	.118	.496	.404	.430	-.231	.737**	.377	.287

Note. Negative correlations resulted generally from high POI scores and low RSQ Rn scores

*p<.05
**p<.02
***p<.01

For the college subgroup, there is only one significant positive correlation. Since 4 subjects in the child-care staff subgroup are also represented in the college subgroup, there are similar negative correlations within both the college and child-care staff subgroups. Within the female staff subgroup, the only significant positive correlation

is between the RSQ Rn scale and the POI Sa scale which measures one's ability to accept oneself in spite of weakness. There are no significant correlations within the male staff subgroup.

Within the non school staff subgroup, a significant negative correlation, r (18) = -.845, $p<.01$, was obtained between the RSQ Rn scale and the POI Sr scale which measures one's perceived self-worth. This same negative correlation appeared in the college staff subgroup. In addition, there was a significant positive correlation, r (18) = .948, $p<.01$, between the POI C scale and the RSQ Rn scale.

No significant correlations were found within the social work subgroup. Within the non social work subgroup, there was a significant positive correlation, r (20) = .607, $p<.01$, between the POI C scale and the RSQ Rn scale. These latter findings are consistent with the results obtained for the total group (see Table 3 above).

Mean scores for POI scales were plotted for the total group as well as for each subgroup. Figure 1 illustrates the POI profile for the large group. Mean scores for the POI scales SAV, Fr, S, Sr, and A are elevated and fall within the self-actualized range. The mean score for the S scale, in particular, is

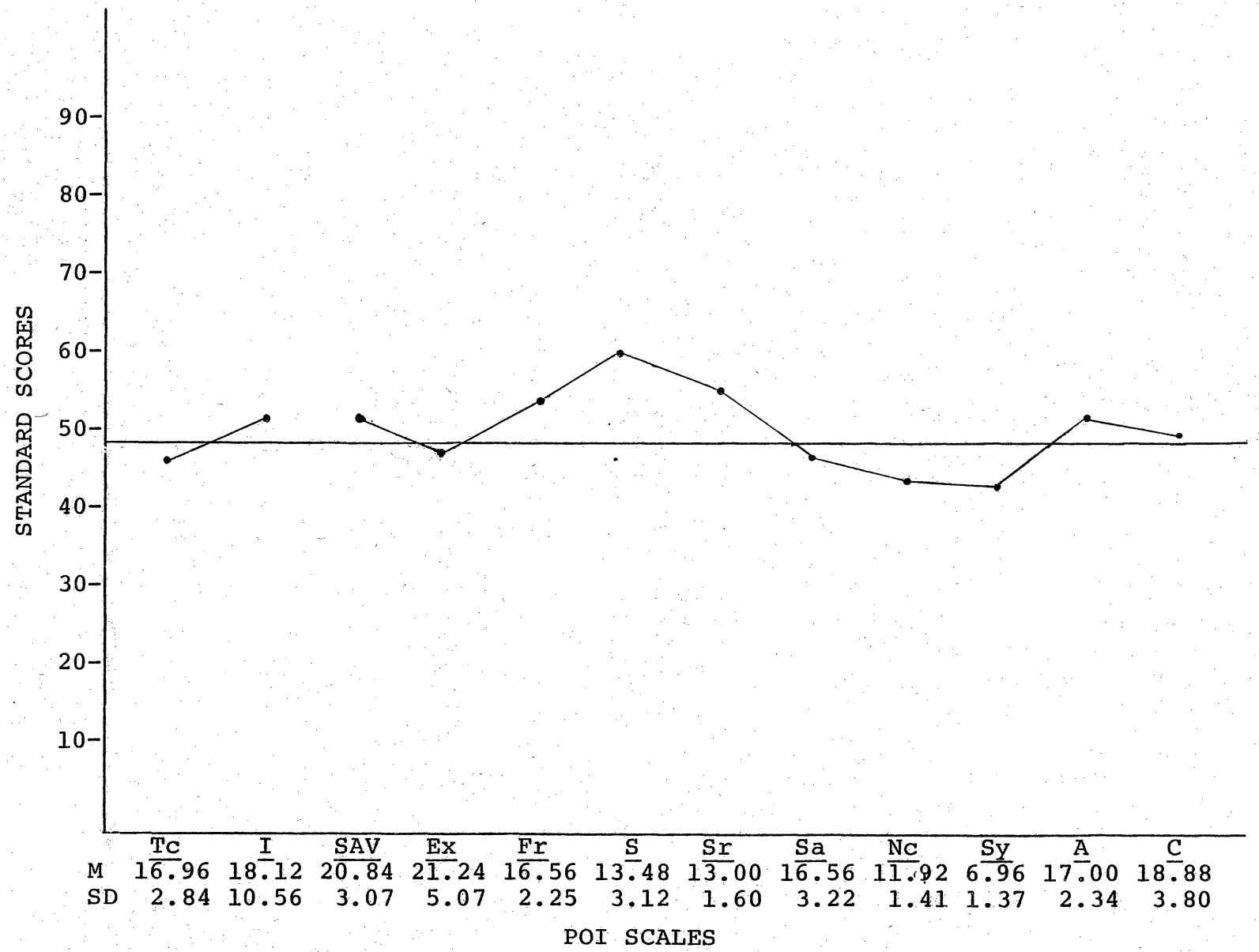

Figure 1. POI profile for total group mean scores.

significantly different from POI adult norms, *t* (180) = 2.89, *p*<.01. Furthermore, there is a notable decline in the *Sa* scale mean score. Although the *Sa* mean score is within the normal range, it is significantly lower than the highly elevated *S* scale mean score, *t* (48) = 2.85, *p*<.01. With respect to the overall profile pattern, profiles for each subgroup were virtually identical to the total group profile.

For the most part, differences between subgroup POI mean scores were not significant. Table 7 shows the only 3 sets of significantly different scores, excepting the college and non college subgroups.

Table 7

Statistical Differences Between POI Means for Subgroups

Group	Scale	Mean	SD	Mean	SD	*t*
Child-care vs non child-care	*A*	18.5	1.41	16.29	2.39	2.45*
Operational vs Primary Service	*SAV*	19.11	3.01	21.81	2.73	2.34*
	A	15.77	2.16	17.68	2.21	2.08*

Note. These were the only significant differences found throughout the subgroups excepting the college and non college subgroups.

*$p<.05$, 1 tailed, 23 *df*

Table 8 presents the mean scores between the college and non college subgroups. Between these two subgroups, there are 6 sets of scores with significant differences.

Table 8

Statistical Differences Between POI Means for College and non College Subgroups

POI Scale	College Mean	College SD	Non College Mean	Non College SD	t
I	97.66	8.03	84.31	8.69	3.785***
SAV	22.22	1.56	20.06	3.47	1.756
Ex	24.77	2.48	19.25	5.11	3.02***
Fr	17.88	2.14	15.81	2.0	2.41*
S	15.0	3.39	12.62	2.70	1.924
Sr	14.0	1.11	12.43	1.59	2.61**
Sa	17.66	3.39	15.93	3.06	1.31
A	18.55	1.58	16.12	2.27	2.82***
C	21.66	2.39	17.31	3.57	3.25***

*$p<.05$
**$p<.02$
***$p<.01$ 1 tailed, 23 df

Although the social work subgroup scores appear to be significantly different from the non social work subgroup

scores, no statistical tests were performed because the social work subgroup is quite small, and the same data are already contained in the college staff subgroup.

POI profiles were plotted for each subject in the total group. These profiles were in many cases representative of various selected reference groups previously involved in POI research. The similarities were in most cases consistent with either a subject's job role or life situation, for example, service organization volunteer, well-adjusted business man, and college freshman. Several subjects' profiles were representative of either the pseudo-self-actualizing person or the person attempting to make a good impression.

The pseudo-self-actualizing profile is indicative of a subject who is most often a college graduate, has studied psychology, and tends to respond to the questionaire intellectually rather than spontaneously. Fifty-five percent of the college subgroup individual scores and forty-four percent of the child-care staff subgroup individual scores resemble the pseudo-self-actualizing profile. Figure 2 illustrates a pseudo-self-actualizing profile of a child-care worker who is also a college graduate. Notice also the decline in the Sa scale score which is characteristic of the total group.

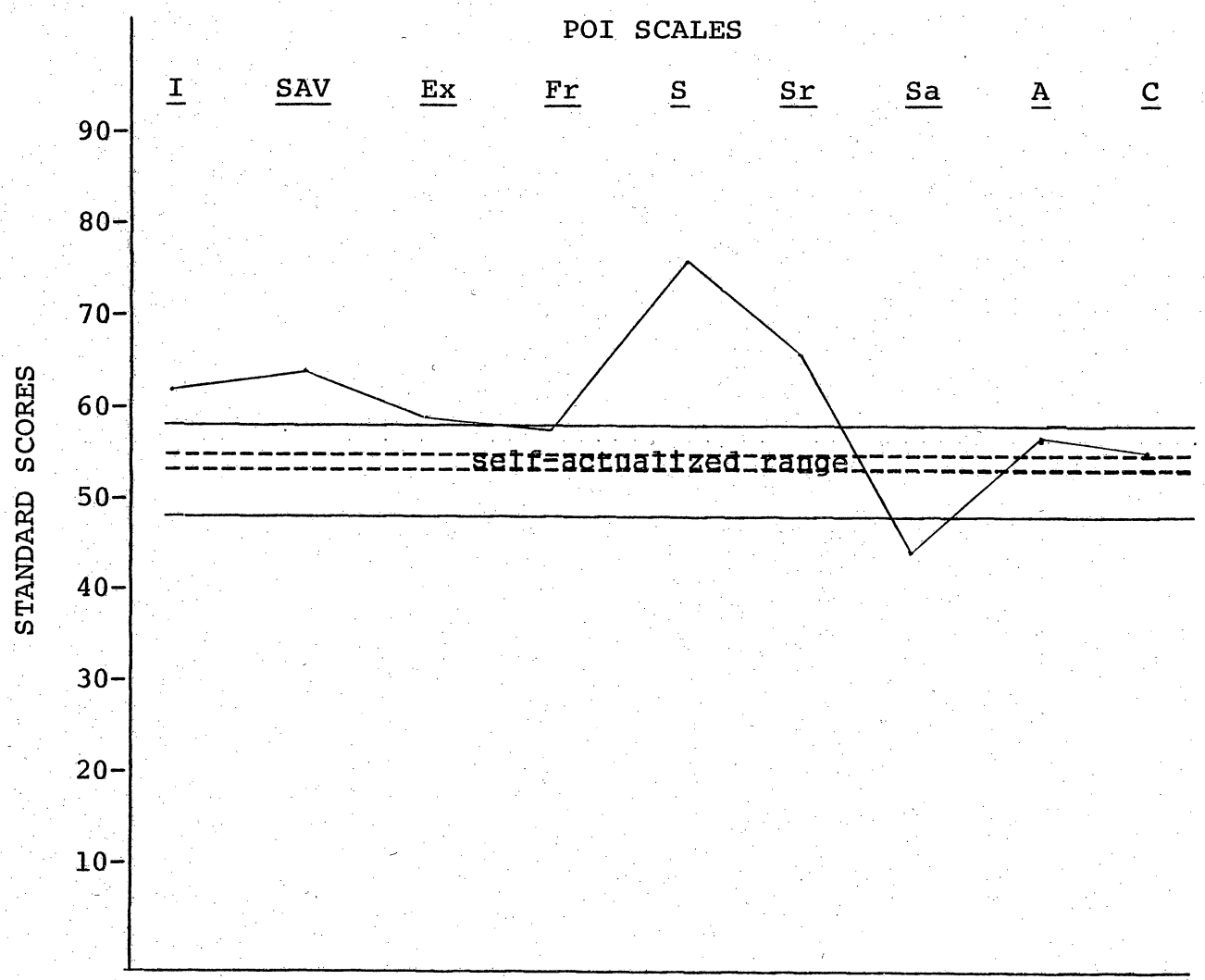

Figure 2. POI profile of a child-care worker whose scores fall in the pseudo-self-actualized range.

With respect to the good impression profile, the combination of a high SAV score and a contrastingly low Ex score is the primary indicator. According to prior research (Knapp, 1971), this profile is typical of an employee who compulsively fulfills all obligations and wants to give the impression of being a strong organizational man. The subject with the good impression profile did, in fact, obtain a very high RSQ institutional control score of 7.

With respect to the RSQ, mean scores for each of the subgroups were compared. Table 9 provides RSQ mean scores for the total group. From a statistical point of view, the scores are distributed as expected with the total group responding fifty percent of the time in the residents' needs direction and fifty percent of the time in the control direction.

Table 9

Residential Staff Questionaire

Total Group Mean Scores

	RSQ Scales			
	Pc	Rn	Ic	Cs
Mean	2.44	5.22	2.22	4.66
SD	1.82	3.05	1.92	3.06
n = 27				

In contrast to the even distribution of the total group scores, child-care staff obtained significantly higher control scores. On the other hand, school and social work staff obtained significantly higher Rn scores. Table 10 presents RSQ mean scores for 6 subgroups where significant differences were found. These results are quite similar to those of the pilot studies cited earlier (see Table 2).

In summation, the results support the hypothesized relationship between positive mental health and awareness of residents' needs for non college and non child-care staff. The negative correlations found in the college and child-care staff subgroups will be the focus of the following discussion.

Table 10

Statistical Differences Between RSQ Means for Specific Subgroups

	RSQ Scales			
	Pc	Rn	Ic	Cs
Child-care Staff				
Mean	4.0	2.62	3.25	7.25
SD	1.77	2.13	1.83	2.18
n = 8				
Non Child-care Staff				
Mean	1.82	6.58	1.47	3.29
SD	1.42	2.37	1.41	2.36
n = 17				
t	2.39*	4.01***	2.66**	3.98***
School Staff				
Mean	1.0	7.6	1.2	3.4
SD	1.0	2.3	1.3	3.7
n = 5				
Non School Staff				
Mean	2.9	4.75	2.25	5.15
SD	1.8	2.84	1.80	2.87
n = 20				
t	2.24*	2.36*	1.51	1.29
Social Work Staff				
Mean	1.0	8.6	.33	1.33
SD	1.0	1.5	.57	1.52
n = 3				
Non Social Work Staff				
Mean	2.72	4.86	2.27	5.0
SD	1.83	2.79	1.72	2.82
n = 22				
t	1.58	2.25*	1.92	2.19*

*$p < .05$
**$p < .02$
***$p < .01$ 1 tailed test, 23 df

DISCUSSION

The results of this study support the hypothesized relationship between positive mental health and awareness of the needs of residents for specific subgroups, namely non child-care staff, non college staff, and operational staff. Within these 3 subgroups, staff, with an increased awareness of their own personal development, showed a correspondingly increased awareness of residents' needs and were consequently less dependent upon personal and institutional control tactics.

For the alternate subgroups, namely, child-care staff, college staff, and primary service staff, high POI scores and low RSQ Rn scores resulted in low and negative correlations. It is speculated from these results that college education and training provide an intellectual awareness of those qualities and characteristics associated with personal mental health. However, college does not necessarily provide the employee with the capacity to relate to disturbed residents in a therapeutic way. It is concluded that hiring college graduates does not eliminate the need for an on-going inservice training program designed to assist staff both in the development of themselves as persons as well as their interpersonal

skills with residents. These findings support Bettelheim's (1966) experience that an educated staff does not preclude the necessity of training. He reports finding it easier to help the housekeeper to accept a resident's verbal abuse, or the cook to accept food waste, than to help a psychologist accept schizophrenic behavior.

Had high POI scores within the latter subgroups been only slightly elevated and within the self-actualized range, then one might have speculated that the results support the viewpoint that people-changing organizations fall somewhere in the middle of the treatment-custody continuum, and that there are, almost by necessity, treatment and non-treatment components alike in any given setting (Moos, 1975). One might even have concluded that child-care staff are by necessity so physically and emotionally close to the residents that it is impractical to speak of a relationship between positive mental health and awareness of residents' needs. As one child-care worker said in a follow-up interview, "If I get too caught up in being aware of their needs, they'll take advantage of me." This would support Cressey's (1965) viewpoint that it is not staff's positive mental health but rather organizational conditions which produce staff behavior conducive or contrary to treatment goals. Although the above line of speculation cannot be completely dismissed

in view of the results of this study, it is nevertheless countered by the high positive correlation between the POI C scale and the RSQ Rn scale. This finding was not specific to any particular subgroup, but was true of the total group, and was the one significant finding in the analyses of the total group scores.

To better understand the implication of the correlation between the POI C scale and the RSQ Rn scale, it is necessary to look at the theoretical construct underlying the C scale. According to Shostrom (1961), the capacity for interpersonal relationships is the ability to relate to another person without the contingencies of obligation, appreciation, or approval. It means the freedom to express both warm and hostile feelings to the other person. Of particular importance is an awareness of one's own needs in the relationship as well as the liberty to allow the other to see one's weaknesses. As cited previously, interpersonal relationships are the basis for a therapeutic milieu. Perceptions, held by significant others, of the resident's capacity to change, directly affect the resident's own perception of his or her ability to change (Tanner, Lindgren, 1971). Redl's (1966, p. 303) experience at Pioneer House further validates the importance of interpersonal relationships between staff and residents. He concludes that "tax free

love and gratification grants" are a must in a treatment setting. The resident must receive plenty of affection and acceptance whether he or she deserves it or not. He or she must be assured of a "basic quota" of gratifying life experiences whether he or she has it coming or not. Of interest to this study, Redl points out that the staff person's ability to relate to residents in this manner is not linked to professional training. Similarly, Easson (1969) underlines the necessity of staff learning to reap personal rewards from the residents' success in fulfilling their potential and developing their individuality. When staff become victims of their own need to succeed, they find it difficult to relate to a resident who generally tends to be unsuccessful in his or her personal development. On the other hand, when staff can provide an accepting relationship for the resident, the resident begins to overcome anxiety about his or her inadequacy. The resident no longer needs to risk rejection but can rely upon the emotional support of the staff to work on his or her problems.

Finally, the results seem to indicate that staff need to become more comfortable with their individual weaknesses and limitations. Within both female and operational staff, there was a significant positive correlation between the POI Sa scale and the RSQ Rn scale. However, these results

were not true of any other subgroup nor of the total group where a significant decline in the Sa scale was noted. As mentioned above, the acceptance of self in spite of weakness is important with respect to interpersonal relationships between staff and residents. However, this factor is also a critical treatment component with respect to interpersonal relationships among staff (Bettelheim, 1966). In order for the resident to receive maximum benefit from the total program, staff need to share with one another what is happening between themselves and the residents. This is a threatening adventure since staff commonly perceive as weakness or ineffectiveness their inability to control a resident or to produce changes in behavior. Previously cited practitioners have clearly demonstrated that once staff remove the focus from power struggles to the resident's own behavior, a process takes place whereby the staff gain control of the problematic behavior and the resident gains control of himself. However, this process cannot begin to occur until staff are comfortable in giving up power struggles among themselves, for example, child-care staff against non child-care staff. In developing an effective inservice training program, Bettelheim (1966, p. 697) stresses the importance of staff first being convinced that they are all in the same boat together, that successful treatment depends upon

everybody rowing together, and that "no oar carries the label of a particular profession."

In conclusion, the results of this study reconfirm the need for on-going inservice training for all levels of staff, college and professionally trained not excepted. Inservice training needs to focus on two issues: personal development and awareness of residents' needs. The results indicate that staff who are either static or only intellectually involved in their personal development show a correspondingly decreased capacity for awareness of residents' needs and rely upon personal and institutional control tactics in their interactions with residents. Furthermore, the results suggest a need for staff to become more comfortable in accepting their own limitations in bringing about behavioral changes in residents as well as giving up personal control over them, a process parents commonly find troublesome (Swift, 1966).

There are some limitations to this study, particularly the small sample size. The conclusions are consequently limited and generally speculative in nature. An increase in sample size, in itself, may have eliminated the negative correlations within some of the subgroups. Many of the subjects who are students equated their involvement with the project with school testing. The effects of this set are difficult to assess or control. Additional validity studies with the RSQ as well as replication of this study

is advised within a variety of institutional settings: hospitals, schools, boarding schools, closed as well as open treatment settings, girls' facilities as well as coeducational facilities. Continued development of the RSQ could result in a useful instrument in measuring the effectiveness of inservice training programs. Furthermore, since both test instruments are self reports and provide no data regarding actual job performance, the assumption that there is a correlation between the results of the self report and job performance has to be made with caution and may well be false. What is needed is an instrument to measure actual job performance as well as an instrument whereby such constructs as awareness of residents' needs are rated by the residents themselves.

APPENDIX

RESIDENTIAL STAFF QUESTIONAIRE

In recent times, there have been many new theories on how to handle young people in trouble. It sometimes seems that those who have the most to say about the topic are not the people who, like yourself, are actually working with these youngsters.

There are different opinions about the care and treatment of these young people who must be placed in Boys Homes and treatment centers. We hear from politicians, psychologists, ministers, judges, and doctors, but rarely do we hear from you, the people who actually live with and care for them.

We are hoping, through this questionaire, to hear from you, the people who work with our troubled youth. What are your ideas? How can we best meet the needs of these youngsters?

INSTRUCTIONS

This questionaire presents 10 situations common to institutional settings. Each situation has 3 possible solutions. There are no right or wrong answers, so simply choose the solution which best describes your personal approach to working with troubled youth or which best explains the way you personally would handle these various situations. Select only one solution. Circle and darken the appropriate letter on the answer sheet. Please do not write on the questionaire.

SAMPLE

S. SITUATION: JOHNNY RETURNS FROM A HOME VISIT TWO DAYS LATE WITHOUT GOOD CAUSE.

A. Johnny owes the institution 2 days from subsequent visits.

B. Johnny should be given a second chance since part of the responsibility lies with his parents.

C. Johnny should be restricted from his next home visit to set both limits for Johnny as well as an example to the other youngsters.

If you decide to choose solution A, for example, then circle and darken A on the answer sheet.

THIS IS THE SAMPLE. NOW BEGIN WITH NUMBER ONE.

1. SITUATION: THE YOUNGSTERS WHO COME TO THE TREATMENT CENTER ARE OBVIOUSLY NOT GOING TO STOP MISBEHAVING THE MOMENT THEY ENTER THE FACILITY. IN GENERAL, HOW DO YOU BEGIN HELPING A YOUNGSTER TO CHANGE?

A. One of the most difficult and yet most important parts of my job is providing these youngsters with an understanding and an acceptance of their anger and hostility. Odd as it may sound, there are times when a youngster might need to break a window or run away. It is a strange thing, but only when I accept the delinquent behaviors as a significant part of a youngster's present state, will the youngster himself accept responsiblity for his misdeeds and begin the long process of growth and change.

B. Part of my job is to provide these youngsters with the structure and discipline of which they have been deprived. It is interesting that they themselves will often tell me that I am too easy on them. An important and difficult part of discipline and structure is preventing and controlling delinquent behavior. Obviously, I cannot teach them new ways of behaving if I allow them to constantly go through their changes and act out in their old ways.

C. Basically, it is very simple. Once a youngster understands that he receives from other people the same treatment he himself gives, he will develop that respect for adults and authority necessary for his change and growth. Unfortunately, there are some youngsters who will not learn and therefore should not be placed in an open setting since they will have a negative influence on those who can change. It is like the old saying, "one bad apple spoils the barrel."

2. SITUATION: TIM, THE LARGEST BOY AT THE TREATMENT CENTER, IS 6 FEET TALL. ALTHOUGH YOU HAVE HAD NO PRIOR ALTERCATIONS WITH TIM, BOTH OF YOU ARE AWARE OF SOME TENSION BETWEEN YOU. ON A PARTICULAR EVENING, TIM CHALLENGES YOU BY REFUSING TO LEAVE A FRIEND'S ROOM TO GO TO HIS OWN TO PREPARE FOR BED. TIM ACTUALLY PUSHES YOU AND TAUNTS, "SEE IF YOU CAN MAKE ME, MOTHER FUCKER." A CROWD QUICKLY GATHERS.

A. Unfortunately, this kind of challenge is often a signal that a youngster is not able to function in this type of open setting. Older and physically mature youngsters, in particular, need to know that they cannot use their physical prowess to gain control of the institution. Tim probably needs to be physically subdued so that he, as well as his peers, will understand who is in control. If necessary, call the local law enforcement agency and have Tim removed to juvenile hall. Besides doing the best thing for Tim, you will also be setting an example of institutional limits for the other youngsters.

B. A youngster's inability to ask for the affection he needs in an appropriate way often results in this type of conflict. With this in mind, focus on Tim's challenge. Most likely, he is directing his defiance solely at you, and so back off quickly and allow Tim as little attention for his challenge as possible. Avoid requesting any "crowd" to disperse because you will only be setting up an additional confrontation with Tim's peers who might, at this point, join Tim in his defiance. One easy way to handle the situation is to request another child-care worker to "trade" units for the evening's bed preparations. On the following day then, get together with Tim, along with another staff person, to work through this mutual power struggle. In general, we tend to overlook our own importance to the youngsters as well as forget about their lack of interpersonal skills.

C. For all practical purposes, Tim is attempting to take over control of the unit. You cannot allow him or the others to think that he is in any way successful in his challenge to your authority. Timing is an important element here, and the longer you refrain from action, the greater

advantage Tim gains especially when there are other youngsters watching. Avoid turning your back on Tim. This type of body language communicates fear and surrender on your part and Tim gains a sense of victory. One can become too concerned with analyzing Tim's challenge and thus lose control. You must be prepared to see to it that Tim carries out your instructions.

3. SITUATION: IN SOME TREATMENT CENTERS, AFTER ONE OR ALL OF THE MEALS, THERE IS A STRUCTURING SESSION DURING WHICH IMPORTANT ANNOUNCEMENTS ARE MADE. GETTING THE YOUNGSTERS TO QUIET DOWN AND LISTEN CAN BE A PROBLEM. SOME YOUNGSTERS WILL HORSE AROUND AND ATTEMPT TO DISRUPT THE SESSION.

   A. It should not be too surprising if the youngsters seemed uninterested in the announcements. This problem is similar to the president of a local club or lodge attempting to call a meeting of adult members to order! One must use his imagination in developing ways to hold youngsters' attention, for example, begin the announcements in a whisper. It is amazing how quickly everyone quiets down.

   B. Kids are bound to be smarting off during these structuring sessions, so you have to expect some of it. However, it is still important to be firm. Let them know that you will not tolerate it. A few nights of extra kitchen duty or restrictions from activities will cure this problem fast.

   C. Commanding the attention of a large group of youngsters is probably one of the most difficult tasks there is. But it is important, nevertheless, and it sets the tone for the entire culture of the organization. It makes it very clear to the youngsters that you are in control, not them. So you must demand their attention.

4. SITUATION: WHAT ABOUT HOME PASSES?

   A. Youngsters should have to earn their home passes. A home visit is one of the most effective tools the institution has for behavior control.

   B. For some youngsters, returning home is a meaningful goal and consequently periodic home visits should

be an automatic part of their treatment program and not dependent upon their behavior. For others, returning home is not a reality and therefore is ineffective as a tool for behavior control.

C. Youngsters will try to soften you up by making you feel guilty if you take away their home pass. But stand firm if they do not earn it. Ordinarily, you need to take away a home pass only once and they will know you mean business.

5. SITUATION: A YOUNGSTER OR GROUP OF YOUNGSTERS RUNS AWAY.

A. This is really tricky business. It is important for the staff to react strongly. Unless the youngsters understand that running way is not tolerated and does not pay off, they will run whenever the going gets rough.

B. Running away is just one more form of defiance. As one becomes more experienced in supervising these youngsters and gains their respect, he will have little problem with runaways.

C. When a youngster runs, he is often running away from something--some consequence he is afraid to face or some kind of hurt. It is a good lesson for the youngster to have to return and deal with problems from which he is running. Running away is generally not contagious as sometimes feared. Therefore the act itself should be ignored and not punished. The youngster should simply be returned to resume where he left off.

6. SITUATION: JOE, A SMALL TO MEDIUM-SIZED YOUNGSTER, WHO HAS NEVER BEEN CONSIDERED A PHYSICAL THREAT TO EITHER STAFF OR HIS PEERS, IS VISIBLY UPSET, BUT THE REASON IS NOT CLEAR. WHILE STANDING IN LINE FOR A SNACK, JOE IS CONFRONTED BY A STAFF MEMBER FOR MAKING A GROSS REMARK ABOUT THE FOOD. FEELING BACKED UP IN A CORNER, JOE PANICS AND CHARGES INTO THE KITCHEN AND GRABS A KNIFE FROM A FOOD PREPARATION TABLE AND TELLS THE STAFF PERSON NOT TO COME ANY CLOSER.

A. Immediate action by the staff is required. Joe needs to be quickly overpowered--carefully of

course. This is the worst type of acting out that can happen in a treatment center because of the contagious factors. Unless Joe is severely punished or removed from placement, a rash of similar incidents will follow. In addition, this is an obvious sign that Joe needs a more intensive psychiatric placement for his depression and paranoid symptoms and cannot function in an open setting.

B. Call for help and back away from Joe with your eyes on the knife. Direct the kitchen personnel to also back away and allow Joe plenty of room. Talk to Joe in a very nonthreatening way, apologize for getting on his case, and request that he put the knife down. If you are afraid, tell him so. When one or more staff persons come to your aid, then consider leaving the room. Joe might be able to more easily surrender to one of the other staff persons. When Joe surrenders the knife, he should be held and soothed. This is not the moment for a lecture.

C. Joe obviously feels cornered and threatened by the staff person and subsequently feels stronger and more secure with the knife. Nevertheless, this is not the time for sympathy. Tell Joe in a loud strong voice to put the knife down and move toward him slowly, but indicate by your body language that you are not afraid and that you do intend to overpower him. These rare occasions validate the reasoning behind unwritten physical prerequisites for child-care staff. Physical strength is a definite asset in instilling a healthy fear in a youngster.

7. SITUATION: FOUR YOUNGSTERS ARE FOUND SNIFFING PAINT FOR THE THIRD NIGHT IN A ROW.

A. Find some films on sniffing so they can learn what it actually does to their brains. Let them know how much you care about them and how it hurts you to see them destroy their brains. Some school districts now have special classes to educate youngsters as to the dangers of sniffing and drug abuse, so inquire about such programs in your area. Sometimes just knowing that someone really cares is enough motivation for them to stop. Avoid letting the youngsters sidetrack the issue by answering their questions, such as, "why do you drink?" or "don't you like to get high?".

B. Meet with the youngsters after they have sobered up--usually the next day. Let them know that you understand that they must be really hurting inside and that you recognize that this is their way to alleviate their pain. This is where you begin.

C. Sniffing can be very contagious. If you do not stop this type of behavior quickly, the entire unit will be sniffing. Make a clear contract with the youngsters that further sniffing will lead to their removal from the facility. Be sure to follow through with the contract. Unfortunately, this method may not be successful in correcting the sniffing, but it deters other youngsters from giving it a try. Sometimes, the fear of being removed from placement and having to return to juvenile hall is sufficient in helping a youngster to overcome such self-destructive habits.

8. SITUATION: BOB HAS HAD ONE OF THOSE BAD DAYS. TO BEGIN WITH, THERE WAS A HASSLE IN GETTING UP THIS MORNING, HE WAS LATER SUSPENDED FROM SCHOOL, AND WAS THEN TOLD THAT HE HAD LOST HIS WEEKEND HOME PASS. FINALLY, AT THE DINNER TABLE, ANOTHER YOUNGSTER'S REMARK ABOUT HIS MOTHER SENDS HIM INTO A FURIOUS RAGE.

A. Ideally, Bob should be placed in a padded isolation room. When a youngster is having this kind of a tantrum, there is really nothing one can do to reach him. Trying to control him is a dangerous risk to your own physical well-being. If there is a doctor available, medication should be considered. This might be a warning sign to reread Bob's file to gain additional clinical information.

B. It is important to handle this situation firmly since the other youngsters are watching your reaction very closely. If they notice that you are afraid of Bob or see that Bob can get away with this kind of acting out, they will in turn try to manipulate you with temper tantrums when things do not go their way. Therefore, you must gain physical control of Bob quickly and forcefully. Needless to say, you do not hurt Bob, but you do instill in him, and in those watching, just enough fear to prevent this type of acting out in the future. It is important to teach Bob

to talk out his frustrations instead of acting them out.

C. At this point in his day, Bob is really hurting and needs comforting. Two or 3 staff persons should work together in bringing him under physical control in as gentle a way as possible. Talk to Bob in a soothing voice and let him know you understand his pain. In these types of situations, rubbing the person's forehead with a cool wet towel is often a good first aid. If the timing is right, Bob's peers can also be brought in to help him work through his frustration. Acting out can be an important step in learning other forms of emotional expression.

9. SITUATION: WHEN JOHNNY IS TOLD THAT IT IS HIS TURN TO MOP THE DINING HALL, HE IMMEDIATELY RESPONDS WITH, "FUCK YOU." THIS INCIDENT IS WITNESSED BY OTHER YOUNGSTERS.

A. The youngster must be brought under control and made to mop the floor. Allowing this kind of acting out leads to chaos and soon no one will be following any direction. This youngster must learn to respect adult authority. As a general rule, verbal abuse by youngsters should not be tolerated and by no means should a staff member allow himself to be physically abused.

B. The most effective response would be a light slap since, unfortunately, this is all that some of these youngsters understand. However, since corporal punishment is forbidden by the State, physically remove Johnny to an office and isolate him from his peers, and in so doing, be very forceful. This is the time to show your physical and moral strength.

C. First, check yourself: are you angry and in the right frame of mind to handle this alone or do you need some assistance from your fellow staff? Second, reflect back on Johnny's day, for example, what happened at school or what's happening for tomorrow. Third, appoint a substitute or request a volunteer to work to get the floor mopped. Allow Johnny to leave the dining hall and <u>later</u> confront him with his behavior. There are times when a youngster needs to be given some leeway to regress and escape.

10. SITUATION: WAKING UP THE YOUNGSTERS HAS TO BE ONE OF THE MOST DIFFICULT TASKS IN A CHILD-CARE WORKER'S DAY. HOW DO YOU GO ABOUT IT?

A. There are numerous techniques to ease youngsters from a state of sleep to activity without getting them so "hyper" that the task of waking up is simply the first of numerous confrontations. Begin by gently waking the youngster some minutes before it is actually time and inform him in a reassuring way that he has a few more minutes to sleep. As a rule, never shout in the morning, nor ring jarring bells, and do not pull off covers. This latter can be especially embarrassing for a youngster who is self-conscious about erections or a bed-wetting problem. If physical contact is necessary, be gentle. Light music is often a good way to arouse youngsters.

B. This is a most difficult task. Research that indicates the contrary was performed under ideal or unreal conditions. There is no way to make "hitting the deck" easier especially on a cold morning. Simply enter the room, turn on the lights, and in a neutral tone of voice, inform the youngster that it is time to wake up. If two or three additional requests over a five-minute period do not bring results, then the uncomfortable confrontation must follow. Remove the blankets and remind the youngster of the events in the coming day from which he will be restricted if he does not get up. This almost always brings an immediate response. Youngsters will tell you themselves that they do not like having their blankets pulled back--it obviously makes it more difficult to make up the bed--and they do not like restrictions.

C. Getting up is really difficult--for the staff as well as the youngsters! It will always be difficult no matter what you do to make it easier. There is only one solution. Either a youngster gets up with a minimum amount of coaxing or else it is early bedtime for each offense. When the youngster complains about the early bedtime, simply state to him that it is obvious that he needs more sleep because he cannot get up on time. Some researchers have tried ingenious ways to wake people, for example playing music and providing incentives, but results were inconclusive. Nothing will take away from the fact that it is

just plain difficult to get up in the morning. The more important issue is, of course, setting institutional limits and providing the youngster with the much-needed structure that has been lacking in his life.

END

ANSWER SHEET

Residential Staff Questionaire

NAME_____ DATE_____ AGE_____ SEX_____

INSTRUCTIONS. This answer sheet is for recording your responses to the Residential Staff Questionaire. Read each solution in the questionaire and decide which solution best describes your personal approach to working with troubled youth or which best explains the way you personally would handle the particular situation. Circle and darken the corresponding letter on this answer sheet. Select only one solution. If you wish to change your answer, erase your first mark completely. Do not write on the questionaire.

SAMPLE.	A	B	C
1.	A	B	C
2.	A	B	C
3.	A	B	C
4.	A	B	C
5.	A	B	C
6.	A	B	C
7.	A	B	C
8.	A	B	C
9.	A	B	C
10.	A	B	C

RESIDENTIAL STAFF QUESTIONAIRE

SCORE SHEET

NAME_____

	Pc	Rn	Ic
1.	B	A	C
2.	C	B	A
3.	B	A	C
4.	C	B	A
5.	B	C	A
6.	C	B	A
7.	A	B	C
8.	B	C	A
9.	B	C	A
10.	B	A	C

TOTAL:_____

Pc + Ic:_____ Cs Score

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